Chapter IV

Medicaid for Aged, Blind, and Disabled

Program Summary

What is Medicaid?

Medicaid is a government health insurance program for low-income persons who are elderly, disabled, or blind (and for low-income families with children and pregnant women). Medicaid is different from Medicare. Some elderly and disabled individuals are eligible for both Medicaid and Medicare. Medicaid makes payments directly to hospitals, doctors, nursing homes, pharmacies and others who provide covered health care services to eligible Medicaid recipients.

Who Can Get Medicaid?

Elderly, blind, or disabled persons may be eligible for Medicaid if they receive or would be eligible for SSI benefits, if they receive State-County Special Assistance benefits, if they are "categorically needy" or "medically needy," or if they are low-income Medicare beneficiaries.

How Does a Person Get Medicaid?

Elderly or disabled SSI recipients are automatically eligible for Medicaid. Other individuals must apply for Medicaid benefits at the county department of social services (DSS).

What Does Medicaid Cover?

SSI recipients, recipients of State-County Special Assistance, and Medicaid recipients who are "categorically needy" or "medically needy" receive "full" Medicaid benefits, including payment for inpatient hospital care, outpatient hospital care, medical treatment physicians, prescription drugs, nursing home care, laboratory and x-ray services, licensed homecare services, eyeglasses, and other covered medical care. Medicaid pays the cost of Medicare premiums and, in some instances, the cost of Medicare deductibles and coinsurance for Medicaid recipients who are low-income Medicare beneficiaries.

What Are the Income Limits?

There are at least three different Medicaid income limits that apply to elderly or disabled individuals who live at home. (Different rules apply for nursing home residents). The 2007 limits are:

Medicaid Category	Single Person Monthly Income	Couple Monthly Income
Categorically Needy	$851	$1,141
Medically Needy	$242	$317
Medicare Qualified Benefits	$1,149	$1,541

What Are the Resource Limits?

The Medicaid resource limits for "categorically needy" and "medically needy" elderly and disabled persons are $2,000 for a single person and $3,000 for a married couple (or $4,000 and $6,000 for Medicare Qualified Benefits.

Medicaid

Introduction

Medicaid is a government health insurance program that pays for medical care for low-income people. It is a complex and constantly changing program. The federal government provides most of the funding for Medicaid and establishes many of the program's requirements regarding eligibility and benefits. Within these federal requirements, however, state Medicaid programs have a significant amount of latitude to determine who will be covered by Medicaid and how much coverage will be provided.

At the federal level, Medicaid is administered by the Centers for Medicaid and Medicare Services within the U.S. Department of Health and Human Services. At the state level, Medicaid is administered by the state Division of Medical Assistance (DMA) within the N.C. Department of Health and Human Services (DHHS). Medicaid is administered locally by the county departments of social services (DSS).

Applying for Medicaid

Applications for Medicaid are taken at county departments of social services (DSS) or, for persons who are applying for Supplemental Security Income (SSI) benefits, at Social Security Administration offices. An applicant must be allowed to apply on the same day that he or she appears at the office. Some hospitals, rural health clinics, and public health departments have staff who can take initial applications for Medicaid, but the application must be processed by the county DSS. Applications can also be filed by mail. An applicant may apply through a representative, who can be a relative, friend, or advocate.

Persons who are applying for SSI do not need to make a separate application for Medicaid unless they are requesting Medicaid coverage for nursing home care. However, disabled persons under 65 should apply (and appeal if denied) at both SSA and DSS. **A person who is over income for SSI or has been denied SSI based on not being disabled may still be able to obtain Medicaid at the county DSS.** If an individual applies for SSI benefits and his or her SSI application is approved, he or she will be automatically approved for Medicaid and will continue to receive Medicaid as long as he or she continues to receive SSI. A newly-eligible SSI recipient also may apply for "retroactive" Medicaid benefits if he or she incurred covered medical expenses during the three months prior to the date

he or she filed an application for SSI and Medicaid. This application for "retroactive" Medicaid benefits must be filed within 60 days of the date the recipient's SSI application was approved.

What Information Is Required?

Much of the information needed for a Medicaid application must be verified by documents or otherwise. As a general rule, the following documents should be brought when applying for Medicaid. (Note, however, that an applicant should not delay in applying if these documents are not readily available. The documents can be produced later in the application process, alternative forms of proof can be used, and county DSS staff must offer to assist the applicant in obtaining necessary information. A delay in filing a Medicaid application may result in Medicaid not paying for some of the applicant's medical care.)

- **Proof of income**, such as wage stubs, award letters from government agencies, etc.
- **Proof of assets**, such as bank books, financial statements, deeds, property tax statements, insurance policies, etc.
- **Social security cards** for all applicants.
- **Immigration papers** for all non-citizens who are applying.
- **Proof of disability** for those applying on that basis, such as medical reports from physicians, but these are obtained by the Disability Determination Service in Raleigh.
- **Birth certificates**, or other proof of age.
- **Proof of citizenship and identity**

Time Frames

Decisions on applications taken at the county DSS should be made within **45 days**, unless the applicant is applying on the basis of disability (in this case, the decision should be made within **90 days**). Decisions on applications taken at the Social Security Administration often take considerably longer; there is no time limit within which SSI-based Medicaid decisions must be made.

A decision approving or denying an application for Medicaid will be in writing and will be mailed to the applicant or the applicant's representative. If an individual's application is denied, the reason for the denial will be stated in the decision and the notice of decision will explain how the applicant may appeal the decision.

Effective Date of Medicaid Coverage and "Retroactive" Coverage

If an individual's Medicaid application is approved, her Medicaid coverage generally is effective as of the first day of the month in which she applied for Medicaid.

An individual may apply for "retroactive" Medicaid coverage if she incurred coverage medical expenses during any of the three calendar months before she applied for Medicaid. For example, if an individual applied for Medicaid on July 31, she could request "retroactive" Medicaid coverage for April, May, and June. For SSI recipients, an application for retroactive benefits must be made at the county DSS within 60 days after the approval for SSI.

For an individual who anticipates significant medical care, such as surgery, it may be advantageous (because of the method used to calculate the deductible for "medically needy" Medicaid recipients) to apply for Medicaid *after* the care has been rendered, as long as it is within the three-month retroactive period. There are certain situations (for example, when access to ongoing medical treatment is critical), however, in which the individual may *not* want to delay applying for Medicaid. Individuals with income over the categorically needy limit may wish to consult with an experienced Medicaid advocate before deciding when to apply. But the resource limit must be met prior to the date for which Medicaid coverage is needed.

Certification Period

Except for SSI recipients, eligibility is generally approved for either a six-month or a twelve-month "certification period." SSI recipients do not have a certification period, unless they are in nursing homes. Before the end of the certification period, the recipient will receive a notice from the county DSS advising her that she must come to the county DSS office to be "recertified." This "recertification" process is slightly less complicated and lengthy than the original application, but it requires verification of certain eligibility factors. If a recipient is not recertified, her Medicaid coverage will terminate at the end of the certification period.

Changes affecting eligibility, such as increases in income or resources, that occur during the certification period must be reported to DSS by the recipient within five days of learning of the change. For SSI recipients, changes must be reported to the Social Security Administration. An individual's Medicaid coverage will be terminated if she no longer meets all eligibility criteria. Advance notice of a proposed termination must be sent to the recipient before her Medicaid benefits may be terminated. If SSI terminates, DSS must determine Medicaid eligibility under other categories before terminating Medicaid.

Nonfinancial Eligibility Requirements

SSI Recipients

Elderly (age 65 or over), blind, or disabled persons who receive Supplemental Security Income (SSI) benefits are automatically eligible to receive Medicaid. Eligibility is determined by the Social Security Administration according to SSI eligibility rules.

State-County Special Assistance Recipients

Elderly (age 65 or over), blind, or disabled residents of adult care homes who receive State-County Special Assistance payments are automatically eligible to receive Medicaid.

Medicare Recipients

Elderly (age 65 or over), blind, or disabled persons who are covered by Medicare (a government health insurance program for elderly, blind, or disabled persons who receive Social Security benefits) and who are over the income or asset limits for full Medicaid may be eligible to receive a *limited* Medicaid benefit that pays the cost of their Medicare Part B premiums if they meet the non-financial eligibility requirements described below and the special financial requirements for the Medicare Qualified Benefit program described in the next section.

Elderly, Blind, and Disabled Adults

An adult who does not receive SSI or State-County Special Assistance benefits may be eligible for Medicaid if he or she meets the non-financial and financial eligibility requirements described below *and* is

- elderly (**age 65 or over**), *or*
- **disabled** (have a severe physical or mental impairment that has lasted or will last 12 months, precludes substantial gainful activity (generally defined as gross earnings over $900 per month), and meets the disability standards adopted by the Social Security Administration, *or*
- **blind** (tunnel vision or corrected visual acuity of no more than 20/200 in better eye).

Residency

A Medicaid recipient must be a resident of North Carolina. In general, a person is a resident of North Carolina if he or she is living in the state and intends to continue living in the state. No minimum period of in-state residency is required. Homeless persons and

residents of homeless shelters may be eligible for Medicaid in North Carolina. Proof of residency is required.

Citizenship and Qualified Aliens

A Medicaid recipient must be a **U.S. citizen** *or* a **qualified immigrant** as described below. Citizens must prove their identity and provide a birth certificate or other evidence of citizenship. A non-citizen who is *not* a qualified immigrant may be eligible for Medicaid only for **emergency medical care** if he or she meets all of the other financial and non-financial eligibility requirements. Qualified immigrants include:

- Lawful permanent residents, conditional entrants, parolees, and certain victims of violence who were first admitted to live in the United States before August 22, 1996;
- Lawful permanent residents, conditional entrants, parolees, and certain victims of violence who were first admitted to live in the U.S. on or after August 22, 1996 *and* who have lived in the U.S. for at least five years;
- Persons admitted to the U.S. as refugees, asylees, trafficking victims, Cuban-Haitian entrants, or certain Amerasian immigrants and persons whose deportation has been withheld;
- Active duty military personnel and honorably discharged veterans and their spouses and dependents.

Other Non-Financial Eligibility Requirements

An individual who applies for Medicaid is required to provide his or her **Social Security number** or apply for a Social Security number if he or she does not have one. Medicaid applicants are required to provide verification of any **other health insurance coverage** that they have or to which they may be entitled and to assign to the state Medicaid program their rights with respect to payments for health care from any insurance company or other third party.

An individual is *not* eligible for Medicaid if he or she is **incarcerated** or a resident of a **public institution** (other than elderly patients in public mental hospitals).

Financial Eligibility Requirements

Income and Resource Limits

SSI and State-County Special Assistance recipients are automatically eligible for Medicaid and do *not* need to meet the

additional financial eligibility requirements described below, except for the transfer of asset rules.

An aged, blind or disabled individual who does *not* receive SSI generally is not eligible for Medicaid unless her **net countable income** and the value of her **countable resources** are less than the **Medicaid income and resource limits** described below.

The Medicaid **resource** limits for an **individual** apply if the applicant or recipient is not married, is married but separated from his or her spouse, is married and living with a spouse who receives SSI or Work First assistance, is a nursing home patient whose spouse lives at home or in another private living arrangement in the community, is a nursing home patient whose spouse lives in another nursing home or in another room in the same nursing home, or is a nursing home patient who lives in the same room as her spouse but the spouse does not request Medicaid. The Medicaid resource limits for a **couple** apply if the applicant or recipient is married and is living with a spouse who does not receive SSI, Work First, or CAP benefits.

Unlike resource limits, the Medicaid **income** limits for an **individual** apply even if the individual lives with a spouse unless the spouse is also applying for and is otherwise eligible for Medicaid (i.e. spouse is also aged, blind, or disabled) or unless the eligible spouse would be income eligible as an individual but for the ineligible spouse's income (in which case more complicated budgeting applies as shown below).

The income and resources of the applicant or recipient are always considered in determining the applicant's or recipient's eligibility for Medicaid. If the applicant or recipient is married and lives with his or her spouse, the income and resources of the applicant's or recipient's spouse generally are considered in determining the applicant's or recipient's eligibility for Medicaid unless the spouse receives SSI, Work First, or is enrolled in CAP. If the applicant or recipient is married and lives in a nursing home, her spouse's income will not be counted in determining her eligibility for Medicaid (except in calculating the community spouse income allowance) but the resources owned by her spouse will be considered in determining her eligibility for Medicaid.

Categorically Needy

An elderly, blind, or disabled person who does not receive SSI benefits and who lives at home may be eligible for Medicaid if the value of his or her **countable resources** is less than **$2,000** (or **$3,000** for a couple) *and* his or her **net countable income** is less than **$851** per month in 2007 (or **$1,141** per month for an eligible couple).

Medically Needy

An elderly, blind, or disabled person who does not receive SSI benefits and lives at home and is not "categorically needy" may be eligible for Medicaid as a "medically needy" person if the value of his or her **countable resources** is less than **$2,000** (or **$3,000** for a couple) *and* his or her **net countable income *minus the amount of incurred medical expenses applied to his or her Medicaid deductible*** is less than **$242** per month (or **$317** per month for a couple) times the number of months in the individual's or couple's Medicaid certification period (usually six months). As described below, medically needy persons are required to meet their Medicaid "deductible" by **spending down** their "excess" income on medical care.

Medicare Recipients

An elderly, blind, or disabled person who is covered by Medicare is eligible to receive a *limited* Medicaid benefit (MQB) that pays the cost of her Medicare Part B premiums if the value or her **countable resources** is less than **$4,000** (or **$6,000** for a couple if both are on Medicare) *and* his or her **net countable income** is less than **$1149** per month in 2007 (or **$1,541** for a couple if both have Medicare). Both MQB and full Medicaid recipients are also automatically eligible for and enrolled in the full Low Income Subsidy (LIS) which pays Medicare Part D premiums, co-payments, and deductibles.

One-Third Reduction

When an individual or couple lives with someone else and does not pay a proportionate share of the household's expenses for food and shelter, the Medicaid income limits noted above may be reduced by one-third, but there are exceptions to this rule.

Nursing Home Patients

Special income limits and resource rules apply to nursing home patients and persons requesting home- and community-based services under the Community Alternatives Program (CAP). In determining eligibility, the applicant's or recipient's income is counted but the income of the applicant's spouse is not counted unless the applicant and spouse share a nursing home room and both are applying for Medicaid. A nursing home patient may be eligible for Medicaid if:

- His or her *gross* countable income is less than the Medicaid reimbursement rate for that facility *or*
- His or her net countable income minus the Medicaid personal needs allowance is less than the facility's private

pay rate plus the patient's additional unmet medical expenses.

Income

Income is money that a Medicaid applicant or recipient receives from earnings, investments, government benefit programs, or other sources.

The Medicaid income limit for an individual applies if the applicant or recipient is not married, if she is married but separated from her spouse, if she lives in a nursing home and her spouse lives in a different room in a nursing home or lives in the community, if her spouse receives SSI or Work First assistance, or if she and her spouse live together but one or both of them are applying for or receiving assistance under the Community Alternatives Program (CAP).

The Medicaid income limit for a couple applies if an applicant or recipient is married and is living with her spouse and both spouses are applying for and otherwise eligible for Medicaid. The budgeting for an eligible spouse living with an ineligible spouse is more complex.

As noted above, the income of the person who is applying for or receiving Medicaid is always considered in determining his or her Medicaid eligibility. If the applicant or recipient is married, the income of his or her spouse will also be considered unless the applicant or recipient is separated from his or her spouse, his or her spouse receives SSI, Work First, or CAP benefits, the applicant or recipient is a nursing home patient and her spouse lives in the community, in a different nursing home, or in a different room in the same nursing home, or the applicant or recipient is enrolled in a CAP waiver program (see below).

Countable Income

Medicaid eligibility is based on an individual's **net countable income**. Net countable income equals **countable income** *minus* **income deductions**. **Excluded income** is *not* considered in determining the amount of an individual's net countable income.

Unless excluded, all earned and unearned income is considered in determining financial eligibility for Medicaid. **Countable income** generally includes:

- **Gross** wages, tips, commissions, salary, bonuses, overtime, etc.
- Earnings from self-employment, minus operational expenses
- Rental income

- Social Security, veterans', and railroad retirement benefits (**before** deductions for Medicare premiums)
- Annuities, pensions and other retirement or disability benefits
- Worker's compensation and unemployment compensation benefits
- Income from trust funds
- Military allotments
- Alimony
- Lump sum payments, such as a personal injury award (but only in the month of receipt and not including amounts for compensation for lost assets, and not including retroactive Social Security benefits and not including lump sums received by persons already receiving Medicaid)
- Living needs benefits (early payments from life insurance policies)
- Regular contributions of cash
- In-kind contributions of food and shelter, up to a limit of one-third of the Medicaid income limit.

Excluded Income

Not all income is counted in determining eligibility. The following types of income are not counted in determining Medicaid eligibility:

- Supplemental Security Income (SSI) (unless the recipient is in a nursing home)
- The value of Food Stamps and food from other governmental programs
- Work First payments
- Relocation assistance
- Benefits through Title VII of the Older Americans Act
- Bills paid directly by a third party for an item other than food or shelter
- HUD Section 8 payments
- Income of a blind or disabled recipient if the income is needed to fulfill a Plan for Achieving Self-Support (PASS) approved by SSA.
- Tax refunds

- Assistance from other agencies and organizations, whether in cash or in-kind, such as Veterans Administration benefits for aid and attendance (this includes the VA reduced improved pension up to $90), weatherization benefits, disaster assistance, home improvement grants or other social services
- Earned Income Tax Credit payments
- Irregular or infrequent income that is not received on a regular basis
- Reverse mortgage payments
- Loans, if there is an agreed upon repayment schedule
- Home products used by the household, *i.e.,* agricultural products grown and consumed by the household
- Foster care payments
- Grants or scholarships for educational purposes (amounts for room and board not excluded)
- Payments to members of certain classes such as Native Americans, Japanese internment camp victims, and persons exposed to Agent Orange and radiation from nuclear testing.
- Adoption assistance payments
- Incentive or training allowances and supportive services for trainees under the Workforce Investment Act
- Cash received from the sale of a resource or from a casualty insurance payment to replace a resource (but this is considered as a resource if kept into the following month)
- Payments under federal law for restitution, reparations, settlements, etc.
- Payments for supportive services or reimbursement of out-of-pocket expenses made to volunteers in programs such as foster grandparents, senior health aides, senior companions, SCORE, ACE, VISTA, etc.
- VA pensions received by an ineligible spouse
- Income protected for the community spouse of a nursing home resident (see below).
- Interest and Dividends

Income Deductions

All Medicaid applicants (except those whose only income is from a VA pension) are entitled to a standard **$20 per month** income

deduction. Medicaid recipients who are not patients in a long-term care facility and who receive earned income are entitled to an additional deduction of $65 plus impairment-related work expenses or work-related expenses due to blindness **plus one-half** of the remaining amount of their **earned** income. These deductions also apply to income deemed from a spouse.

An eligible person living with an ineligible spouse must first be income eligible as an individual but for the spouse's income. If so, before an ineligible spouse's income is deemed available to a Medicaid applicant or recipient, the county DSS will first deduct a "living allowance" for any ineligible child under age 18 (21 if in school) living in the home ($312 per child in 2007 minus the child's own income) from the ineligible spouse's gross income. If the remaining gross income of the ineligible spouse is less than $312, no income is deemed to the eligible spouse. If the remaining gross income of the ineligible spouse is greater than $312, the combined gross income of the couple is compared to the Categorically Needy income limit for an eligible couple ($1141 in 2007) and all income disregards apply.

Medicaid Deductible for the Medically Needy

Individuals who qualify for Medicaid as "medically needy" (rather than as SSI recipients or "categorically needy" persons) and who are not patients in nursing homes must meet a Medicaid **deductible**. In most cases, the Medicaid deductible is calculated on a six-month basis and is equal to six times the difference between the individual's (or couple's) net countable income and the Medicaid income limit for the medically-needy. For example, an elderly individual with a net countable income of $892 per month would have a Medicaid deductible of $3,900 ($892 minus $242 = $650 times 6 months = $3,900).

The Medicaid deductible often is referred to as the Medicaid **"spend down"** because a medically needy person must "spend down" his or her income in excess of the medically needy income limit by incurring medical expenses. Medical expenses may be used to meet the Medicaid deductible if they are incurred by the individual or couple or the individual's ineligible spouse during the current Medicaid certification period. An expense is *incurred* if the individual or couple is responsible for paying the expense. Thus the portion of a bill that will be paid by Medicare, private insurance, or a third party, or has been written off by the provider, may not be used to meet a deductible.

An incurred medical expense may be deducted even if the individual or couple has not actually paid the bill. Medical expenses that are still owed and were incurred before the current certification period ("old

bills") may be used to meet the deductible if they have not been used to meet the deductible for a prior certification period and if the bills are less than two years old or a payment has been made on the bill within the last two years. The cost of Medicare or other health insurance premiums and other health care expenses, including the cost of nonprescription drugs and other over-the-counter medical supplies and medical transportation costs, may be used to meet the deductible. The deductible is automatically met for the rest of the certification period if the individual is hospitalized if the individual does not have Medicare, but the hospital bill will not be paid by Medicaid.

Once the deductible is met, Medicaid will pay the cost of covered medical services provided to the individual from the date the deductible is met until the end of the individual's current Medicaid certification period. In the example described above, the individual would have to incur $3,900 in medical expenses before Medicaid would pay for his or her remaining medical expenses during that six month certification period. Medicaid will **not** pay the medical expenses that were used to meet the deductible.

When an individual is applying for "retroactive" Medicaid benefits, the amount of the deductible is calculated based on a one, two, or three-month basis, which reduces the amount of the deductible but does not provide ongoing Medicaid coverage unless a second six-month deductible can be met.

Community Spouse Income Allowance (CSIA)

The Community Spouse Income Allowance (CSIA) is an amount that is deducted from the income of a married Medicaid recipient in a nursing home (the "institutionalized spouse") for the support of his or her spouse. The CSIA does not apply if the nursing home patient's spouse lives in a nursing home or if the spouses had been separated for at least twelve months before the institutionalized spouse was admitted to the nursing home (although the latter limitation appears to conflict with federal law). The CSIA must be transferred from the institutionalized spouse to the "community spouse" for the community spouse's support. The amount of the CSIA in 2007 is $1,712 per month (or up to $2,541 per month depending on the community spouse's shelter expenses) *minus* the community spouse's income. A larger CSIA may be sought through a fair hearing or a court support order.

Resources

Resources are assets (for example, money in the bank, personal property, or land) that a Medicaid applicant or recipient (or, in most cases, her spouse) owns and are available for her support. Resources

the individual may retain and still qualify for Medicaid are sometimes called the person's reserve.

As noted above, the Medicaid resource limit for a couple generally applies if an applicant or recipient is married and is living with her spouse (regardless of whether one or both spouses are applying for or receiving Medicaid). The Medicaid resource limit for an individual applies if the applicant or recipient is not married, if she is married but separated from her spouse, if she lives in a nursing home and her spouse lives in a different room in a nursing home or lives in the community, if her spouse receives SSI or Work First assistance, or if she and her spouse live together but one or both of them are applying for or receiving assistance under the Community Alternatives Program waiver (CAP).

Countable and Excluded Resources

Except as noted below, all resources (such as bank accounts, investments, real property, cars, boats, life insurance, revocable trust funds, certain continuing care community entrance fees, and certain irrevocable trusts and annuities) owned by a Medicaid applicant (or, in most instances, by the Medicaid applicant's spouse) are counted in determining her eligibility for Medicaid.

The following types of resources are **not counted** in determining eligibility for Medicaid:

- The applicant's or recipient's home, the property on which the home is located, and all property contiguous to the home if it is owned by the applicant or recipient and used as the applicant's or recipient's principal place of residence.
- The home in which the applicant or recipient formerly lived (and property contiguous to the home) if the applicant or recipient owns the home and her spouse or a dependent relative still live in the home.
- The home in which the applicant or recipient formerly lived (and property contiguous to the home) if the applicant or recipient owns the home and is a patient in a nursing home but states her subjective intent to return to her home (even if her doctor says that she will not be able to return home).

IMPORTANT NOTE: Effective October 1, 2007, if the equity value in the home exceeds $500,000, the individual is ineligible for Medicaid to cover long term care or CAP services, unless the individual or his spouse or minor child or blind or disabled adult child lives in the home. The individual remains eligible for other Medicaid services. This new excess home equity rule does NOT apply to persons continuously receiving Medicaid LTC services since before November 1, 2007. Also the excess home equity rule

will be waived for demonstrated hardship. However, the request for waiver must be made within 12 days of notice of the right to do so. The standard for waiver in the manual is showing that the applicant has no other person able to take care of him if discharged and has no other assets. A denial of demonstrated hardship is appealable under G.S. 108A-79.

- Property contiguous to the applicant's or recipient's home if the applicant or recipient doesn't own the home and the tax or fair market value of the contiguous property is less than $12,000.
- Property that is used to produce goods and services for home consumption if the combined value of such property is less than $6,000.
- Non-business property that produces annual income equal to at least six per cent of its equity value if the combined value of such property is less than $6,000.
- Property that is used in a trade or business, regardless of its value.
- The value of life estates in real property and interests in land held with others as tenants-in-common.
- Personal effects and household goods.
- One burial space per family member
- Irrevocable pre-need burial contracts up to any reasonable value *or* up to $1,500 in separately-identified revocable burial funds.
- One licensed motor vehicle per household, if used for transportation of the applicant/recipient.
- Term life insurance policies, unless they have a cash value.
- The cash value of whole life insurance if the combined face value of such policies does not exceed $10,000.
- Federal disaster assistance or relocation assistance.
- Retirement accounts that cannot be withdrawn as lump sums.
- Awards of retroactive Social Security and SSI benefits for a period of nine months following receipt.
- Earned Income tax credit and child tax credit refunds for 9 months after receipt, even if commingled with other funds.

- Cash or other resources received for repair or replacement of lost, stolen, or damaged excluded resources, for a period of nine months after receipt.
- Educational grants and scholarships for 9 months after receipt.
- Funds held under a Program to Achieve Self Support (PASS) approved by SSA.
- Resources protected under the community spouse resource allowance (CSRA) described below.

Evaluation of Resources

If the value of an applicant's or recipient's resources is less than the Medicaid resource limit as of the **first moment of the first day of the month** and she meets the other non-financial and financial eligibility requirements, she is eligible for Medicaid for that month. Additional resources that the Medicaid applicant or recipient receives during the month will not affect her Medicaid eligibility unless the combined value of her countable resources exceeds the Medicaid resource limit *and* she retains the excess resources on the first day of the following month or she transfers the excess resources for less than market value for the purpose of establishing or retaining Medicaid eligibility.

If a "medically needy" person's resources exceed the Medicaid resource limit on the first day of the month but she reduces the value of her countable resources to an amount less than the Medicaid resource limit during the month (and does not transfer the excess resources for less than market value for the purpose of establishing or retaining Medicaid eligibility), she will be eligible for Medicaid on the first day during the month that she meets her Medicaid "spend down" and all other eligibility requirements. If a Medicaid applicant or recipient is not "medically needy" and the value of her countable resources exceeds the Medicaid resource limit on the first day of the month, she is not eligible for Medicaid for that month even if she reduces the value of her countable resources to an amount less than the Medicaid resource limit during the month.

In general, the value of a countable resource is equal to its **equity value**. Equity value is generally the **fair market value** of the property *minus* the amount of liens against the property. Fair market value generally means the amount for which the property could be sold. In the case of real property (land), the appraised **tax value** is considered its fair market value. In the case of motor vehicles, fair market value is usually based on the value listed in the books published by the National Automobile Dealers' Association

(NADA). The cash value of life insurance is obtained from the insurance company itself.

If an applicant or recipient believes that the value used by the county DSS is more than the actual value of a countable resource, she may attempt to show that the actual value of the property is less. To do so, she must provide evidence from a knowledgeable source regarding the property's actual value (for example, a statement from a real estate broker or appraiser that the actual value of a piece of property is less than its tax value or a statement from a used car dealer that a car's actual value is less than that shown in the "blue book").

Availability of Resources

A resource is not a countable resource unless it is legally available for the applicant's or recipient's care and support. A resource is not an **available resource** if the applicant or recipient does not have the legal right to sell the resource. For example, if the resource is part of an unsettled estate or if the applicant is merely holding the property in his or her name for someone else, it is not available. Likewise, if the applicant is mentally incompetent and has no attorney-in-fact or legal guardian who has the power to sell the resource on behalf of the applicant, the resource is not counted.

Special rules apply to **jointly-held resources**. A jointly-held resource is one that is owned jointly by the applicant or recipient and one or more other persons. Countable resources that are owned jointly by the applicant or recipient and her spouse generally are considered available to the applicant or recipient (in some cases the entire value of the resource will be considered available and in other cases only half of the value will be considered available). Real property that is owned jointly by the applicant or recipient and others as tenants-in-common is not an available countable resource unless all of the co-owners have agreed to sell the property. Except as noted above, the value of the applicant's or recipient's proportionate interest in a jointly-owned counted resource will be considered available if the other co-owners receive Medicaid, Special Assistance, or Work First Family Assistance *or* if the applicant or recipient can sell the property or her interest in the property without the consent of the other co-owners or the other co-owners agree to sell the property.

As noted above, countable resources that are owned by an applicant's or recipient's spouse generally are considered available to the applicant or recipient if the applicant or recipient is living with the spouse. In this case, the applicant's or recipient's Medicaid eligibility is based on the Medicaid resource limit for a couple (unless the spouse receives SSI, CAP, or Work First). This rule also applies if the spouses share a room in a nursing home (unless one

spouse is not requesting Medicaid). When the spouses live in separate rooms in a nursing home or one spouse lives in a nursing home and the other lives in the community, Medicaid eligibility is based on the Medicaid resource limit for a single individual rather than that for a couple.

Community Spouse Resource Allowance (CSRA)

The Community Spouse Resource Allowance (CSRA) rules apply when an individual who is a nursing home patient applies for Medicaid and is married to a spouse is not a nursing home patient. (The CSRA also applies in determining an individual's eligibility for the Community Alternatives Program (CAP)). The CSRA rules allow the "community spouse" to retain all or part of the resources that the couple owns rather than having those resources count in determining the "institutionalized spouse's" eligibility for Medicaid.

The county DSS, upon request of the institutionalized spouse or the community spouse, will determine the amount of the CSRA at any time after the institutionalized spouse is first admitted to a nursing home for a continuous period of at least 30 days. This CSRA "assessment" or "snap shot" may be done before the institutionalized spouse applies for Medicaid.

The amount of the CSRA is based on the value of the countable resources owned by the community spouse, the institutionalized spouse, or the couple as of the first day of the first month that the institutionalized spouse was first admitted to a nursing home for a continuous period of at least 30 days. The amount of the CSRA generally is one-half of the value of these resources but not less than $20,328 or more than $101,640 (2007 figures). For example, if the couple owned $15,000 in countable resources when the institutionalized spouse was first admitted to a nursing home for a continuous period of at least 30 days, the CSRA would be $15,000 (all of the couple's resources would be "protected" for the community spouse and none of the couple's resources would be considered in determining the institutionalized spouse's Medicaid eligibility during the period of protection). If the value of the couple's countable resources was $100,000, the CSRA would be $50,000 ($50,000 protected for the community spouse and $50,000 considered in determining the institutionalized spouse's Medicaid eligibility).

If the institutionalized spouse applies for Medicaid and the community spouse is entitled to the CSRA, the institutionalized spouse will be eligible for Medicaid if she meets all of the other Medicaid eligibility requirements and the value of the couple's combined countable resources as of the month in which the Medicaid application is filed *minus* the CSRA is less than $2,000. If the

couple's countable resources exceed this amount, the institutionalized spouse will not be eligible for Medicaid until the "excess" resources are "spent down." There is no requirement that the excess resources be spent on nursing home care for the institutionalized spouse. As long as the excess resources are not transferred in violation of the transfer of asset rules, they may be spent down in any way the couple desires. This might include purchasing non-countable resources for the sole benefit of the community spouse.

Once the couple's countable resources have been reduced to the CSRA plus $2,000, the countable resources owned by the institutionalized spouse, the community spouse, or the couple will be protected for a period of two to eight months in an amount that does not exceed the CSRA. Countable resources that are included in the CSRA but are owned by the institutionalized spouse must be "spent down" or transferred to the community spouse before the end of the protection period. Countable resources that are owned by the institutionalized spouse and have not been spent down or transferred to the community spouse before the end of the protection period are considered an available resource in determining the institutionalized spouse's continued eligibility for Medicaid. Countable resources retained by, transferred to, or received by the community spouse after the institutionalized spouse is approved for Medicaid do not affect the institutionalized spouse's Medicaid eligibility during or after the protection period. Countable resources transferred to or received by the institutionalized spouse after she has been approved for Medicaid are considered in determining the institutionalized spouse's Medicaid eligibility.

Transfer of Assets Penalty

An otherwise eligible individual may be **disqualified** from receiving Medicaid benefits for **nursing home** care, community and home services under the **Community Alternatives Program (CAP)**, or **in-home and personal care services** if she or her spouse **transfers property for less than its fair market value in order to establish or retain eligibility for Medicaid**. A penalized transfer can include any action to change ownership, waive or renounce assets or income, or change the names on or make withdrawals from a bank account.

The transfer of asset rules have been significantly changed beginning with **transfers made** on or after November 1, 2007. This section summarizes the new rules. In general, the old rules will continue to apply to transfers made before November 1, 2007.

The **transfer of assets penalty** applies only to transfers made *on or after* the beginning of the **"look back"** period. The trigger date or *ending* date of the look back period is called the "starting point." For

applications filed on or after November 1, 2007, the "starting point" is the date the person is **both** admitted to the nursing home (or has requested CAP services) **and** has applied for Medicaid to pay the cost of nursing home care (or CAP services). For applications made before November 1, 2007, the "starting point" is the date she first applies for Medicaid for home health services.

The length of the look back period is gradually being increased from thirty-six to sixty months. If the "starting point" is before November 1, 2010, the look back period is 36 months (except for transfers to a trust or annuity). If the "starting point" is between November 1, 2010 and November 1, 2012, the look back period is always back to November 1, 2007. After November 1, 2012, the look back period is always sixty months. Once established, the look back date never changes.

In the case of a noninstitutionalized person who receives only in-home (non-CAP) services, transfers made after November 1, 2007 will be penalized only if a portion of the sanction period remains after first being applied to institutionalization or a request for CAP services. Transfers made before November 1 are still subject to sanction for in-home services in the first instance.

The transfer of assets penalty applies to transfers made by the applicant or recipient, the applicant's or recipient's spouse, or any person acting on behalf of the applicant or recipient or on behalf of the applicant's or recipient's spouse (for example, a court-appointed guardian). For transfers made on or after November 1, 2007, the transfer of assets penalty will apply to the transfer of any **countable or non-countable resource or income** (including the applicant's or recipient's **home**, tenancy-in-common interests in real property, life estates, exempt automobiles, household goods, jewelry, etc.). For transfers made before November 1, 2007, transfers of most exempt assets **other than the home** are not penalized.

For annuities purchased by the applicant or spouse on or after November 1, 2007, the state of N.C. must be named the remainder beneficiary. Copies of annuity contracts must be provided to DSS. Failure to meet these requirements is treated as a transfer of assets. The purchase of a promissory note, loan or mortgage on or after November 1, 2007 also may be treated as a transfer of assets unless the repayment terms meet certain criteria. The purchase of a life estate in the home of another, a remainder interest, or a fractional interest in real property also may be penalized if certain requirements are not met.

The November 1, 2007 policy change requires the county DSS to request bank statements and other financial documentation for the entire look back period from applicants for CAP or Medicaid

coverage of nursing home care to verify that an illegal transfer has not taken place. DSS must assist in obtaining this information and must accept alternative documentation that provides a reasonable picture of the look back period.

The transfer of assets penalty does *not* apply if:

- The applicant can prove by the greater weight of the evidence that the property was transferred for reasons exclusively other than the purpose of establishing or retaining Medicaid eligibility. Thus, gifts by an individual to charities, a church, or family members *may* not be penalized if part of a "pattern of giving;" *or*
- The Medicaid applicant or recipient received fair market value in return for the transferred property (except for certain purchases of annuities, promissory notes, life estates, and most transfers to trusts); *or*
- The Medicaid applicant or recipient intended to dispose of the property for fair market value but was unable to obtain fair market value; *or*
- The Medicaid applicant or recipient was defrauded or the transferred property has been returned to the applicant or recipient; *or*
- The property was transferred to or for the benefit of the applicant's or recipient's spouse or his or her blind or disabled child of any age; *or*
- The property was transferred by a person other than the Medicaid applicant to a (d)(4) special needs trust for a disabled individual under age 65; *or*
- The property was used to purchase an irrevocable burial contract for the applicant or recipient or his or her spouse, child under the age of 21, or blind or disabled child of any age; *or*
- The asset (not just the home) was transferred to the applicant's spouse, child under the age of 21, or to his or her blind or disabled child of any age; *or*
- The applicant or recipient transferred his or her principal place of residence to his or her child age 21 or over who resided in the residence for at least two years before the applicant or recipient was admitted to a nursing home or requested CAP services and provided care which delayed the need for nursing home care during that two years, or his or her sibling who is a co-owner of the home and resided in the home for at least one year before the applicant or

recipient was admitted to a nursing home or requested CAP services; *or*

- The applicant establishes that the transfer of asset penalty would cause undue hardship, under the standard and procedure set out in N.C.G.S. 108A-58.2, because it would deprive the individual of medical care, such that his health or life would be endangered, or of food, clothing, shelter, or other necessities of life.

If an individual transfers assets in violation of the transfer of assets rules, he or she will be ineligible to receive Medicaid benefits for nursing home care or CAP services for a fixed period of time (but will not be disqualified from receiving other Medicaid benefits during the disqualification period). The length of the **disqualification period** is determined by dividing the uncompensated value of the transferred asset by the average private monthly cost of nursing home care ($5,000 in 2007). For example, if an individual gave away $50,000 in assets in violation of the transfer of assets rules, he or she would be disqualified for a period of ten months ($50,000 divided by $5,000 equals ten).

The applicant/recipient may rebut the presumed value of the asset that was transferred as well as the value of the compensation received in return as well as the purpose of the transfer. Doing so can reduce (or eliminate) the length of the sanction period. A personal care contract can be considered fair compensation for a transfer if it is in writing and certain other requirements are met.

Rounding down is no longer permitted for transfers made after November 1, 2007. This means that fractional portions of a month are now included in computing the penalty period, so that an individual may be penalized for a portion of a month. For a single transfer made before November 1, 2007 of less than $5000, no penalty is imposed. More complex rules apply if multiple transfers were made.

For transfers made on or after November 1, 2007, the disqualification period will not **begin to run** until the **later** of (1) the month in which the asset was transferred; (2) the month in which the individual has been determined "otherwise eligible" to receive Medicaid for long term care or CAP services. "Otherwise eligible" clearly means income and resource eligible, in medical need of nursing facility level of care, and having requested Medicaid coverage. However, the state and federal agencies have interpreted "otherwise eligible" to include actually having been placed in the nursing facility or to have an approved CAP plan of care. This interpretation may become the subject of legal challenge.

For transfers made prior to November 1, 2007, the sanction period begins with the month of the uncompensated transfer. The sanction period runs continuously once it begins.

The sanction period is lifted or erased retroactively if the asset is returned to the applicant or if an amount equal to the uncompsenated value is spent for the benefit of the applicant/recipient. However, the returned asset or funds are counted as assets for the entire period they were not in the name of the applicant, which is likely to result in Medicaid ineligibility for the entire period. If a portion of the uncompensated value is returned, similar but more complex rules apply.

The new undue hardship procedure applies to transfers both before and after November 1, 2007. The individual must request an undue hardship exception within 12 days of notice of the sanction. An additional 12 day period is given to provide evidence of the hardship. A denial of undue hardship, like the transfer sanction itself, is appealable for local and then state hearings (see below).

Medicaid Benefits

Medicaid recipients receive a **Medicaid enrollment card** (much like a health insurance enrollment card) that they must present to hospitals, doctors, pharmacies, and other health care providers who participate in the Medicaid program in order to receive covered medical care and services. Many, but not all, health care providers participate in the Medicaid program.

As a general rule, Medicaid benefits are paid directly to participating hospitals, doctors, pharmacies, and other health care providers who provide covered medical care and services to eligible Medicaid recipients. Medicaid generally does *not* make payments directly to Medicaid recipients.

In some instances, Medicaid recipients are required to make a **co-payment** for covered medical care or services. Although Medicaid will pay for part of the cost of nursing home care for eligible Medicaid recipients, most Medicaid recipients who are patients in nursing homes must pay for part of the cost of their nursing home care (called the **patient monthly liability** or **PML**). Medically needy Medicaid recipients are responsible for the cost of medical care that is applied to their **Medicaid deductible** or "**spend down**." Participating health care providers must accept Medicaid payments as **payment in full** for covered services even if the Medicaid payment is less than the amount usually charged for the service.

Medicaid is considered the "**payer of last resort**." This means that if a Medicaid recipient is covered by Medicare or other health

insurance, Medicaid will require that Medicare or the other health insurance policy pay for the recipient's care before Medicaid pays.

"Full" Medicaid Benefits

Elderly, blind, or disabled SSI recipients, State-County Special Assistance recipients, and categorically or medically needy persons are eligible for "full" Medicaid benefits. "Full" Medicaid coverage includes the following:

- Inpatient **hospital care**;
- Outpatient hospital care ($3.00 co-payment);
- Medical care provided by **physicians** ($3.00 co-payment and general limit of 30 visits per year for all ambulatory physicians' services);
- Clinic services at health department clinics, rural health clinics, and migrant health clinics;
- **Prescription drugs** ($3.00 co-payment for name-brand drugs and $1.00 co-payment for generic drugs; limit of eleven prescriptions per month which may be waived);
- Laboratory work and X-rays;
- Skilled and intermediate level **nursing home care** (payment limited to difference between Medicaid rate and amount of patient monthly liability (PML) described below);
- Home health services;
- Personal care services (adults limited to 60 hours per month or up to 80 hours per month under PCS-Plus);
- Adult health screening;
- Dental care ($3.00 co-payment), dentures (one set every ten years), hearing aids, vision care ($2.00 or $3.00 co-payment), and eyeglasses ($2.00 co-payment and limit of one pair every two years);
- Mental health care, including care at mental health centers, and visits to psychiatrists and psychologists ($3.00 co-payment);
- Mental hospital care for persons age 65 or over;
- Hospice care;
- Payment of Medicare Part B premium for eligible Medicare recipients;

- Durable medical equipment, such as wheelchairs, walkers, canes, hospital beds or other equipment suitable for home use;
- Medical transportation.
- Additional services under EPSDT for recipients under age 21

Nursing Home Care

Eligible Medicaid recipients who are nursing home patients may be required to pay part of the cost of their nursing home care. The portion of the nursing home care that must be paid by a Medicaid recipient is called the **patient monthly liability** (PML). The Medicaid program pays the difference between the Medicaid nursing home rate and the PML.

The PML is calculated by subtracting the following deductions from the recipient's gross monthly income:

- Personal needs allowance ($30 per month);
- Court-ordered guardianship fees (up to $25 per month);
- A maintenance allowance of $242 per month if the recipient is expected to return home within six months from the date he or she was admitted to the nursing home;
- The Community Spouse Income Allowance (CSIA) described above and an allowance for minor dependents who live at home with the community spouse;
- The amount of the recipient's unmet medical needs (health care costs that are not covered by Medicaid, Medicare or private insurance).
- The amount paid to the facility each month under an installment agreement to repay past bills not covered by Medicaid because of a transfer of asset sanction, excess reserve or other reason for Medicaid ineligibility. This provision provides a vehicle to avoid discharge for unpaid bills due to a previous period of Medicaid ineligibility.

If the PML is equal to or greater than the Medicaid payment rate for the nursing home but is less than the facility's private rate, the recipient must pay the Medicaid (not private) rate of nursing home care from her own income but is eligible for Medicaid coverage for other medical care and services (prescription drugs, physicians services, etc.). This provision permits individuals with income higher than the facility's Medicaid rate but lower than its private rate to obtain the lower rate and Medicaid coverage for other needs.

Community Alternatives Program for Disabled Adults

The Community Alternatives Program for Disabled Adults (CAP-DA) provides both medical and non-medical home and community-based services to prevent or delay institutionalization. The program involves an assessment process, development of a plan of care, and ongoing monitoring of service delivery by a case manager. In addition to "full" Medicaid benefits, CAP-DA recipients receive the following services that would not otherwise be covered by Medicaid:

- Adult day health care
- In-home aide services
- Home mobility aids (ramps, grab bars)
- Respite care (in-home and institutional)
- Telephone alert
- Home-delivered meals
- Medical supplies
- Waiver supplies (incontinence supplies, medication boxes)

CAP recipients are exempt from Medicaid co-payments, the eleven prescription per month limit, and the 30 physician visits per year limit. To be eligible, the individual must need nursing facility level of care. The cost of in-home services must be less than the cost of caring for the individual in a nursing home.

There are limits on the number of persons who can participate in CAP-DA, which results in waiting lists in most counties. Another waiver, CAP-DD, covers a different package of services for persons with developmental disabilities. For information about the identity of the lead agency in a county, call the Division of Medical Assistance.

Medicare Premiums, Co-Payments, and Deductibles

Medicaid pays the cost of Medicare Part B premiums for elderly, blind, and disabled persons who are covered by Medicare and meet the eligibility requirements for Medicare Qualified Benefits (MQB).

If a Medicare recipient is also eligible for Medicaid as an SSI recipient or as a categorically needy or medically needy person, she may also receive the full Medicaid benefits described above (including payment of the Medicare Part B premium, the Medicare deductible and coinsurance for covered Medicaid services, and covered Medicaid services that are not covered by Medicare).

Both MQB and full Medicaid recipients automatically are enrolled in the Low Income Subsidy (LIS), which pays Medicare Part D premiums, co-payments, and deductibles.

Estate Recovery

After a Medicaid recipient dies, the state Medicaid program may file a claim against the recipient's estate to recover the cost of certain Medicaid services provided to the recipient. The Medicaid "estate recovery" provisions apply only in the case of

- medical services received by an individual under age 55 while an inpatient in a nursing home or other medical institution and after a determination that he was not expected to return home ,OR
- nursing home care and home- and community-based services, including related hospital care and prescription drugs, received by a Medicaid recipient aged 55 years or older.

The estate recovery provisions do not apply if the deceased Medicaid recipient is survived by his or her spouse, a child under the age of 21 years, or an adult blind or disabled child. Estate recovery may be waived if the amount of Medicaid services provided to the deceased recipient did not exceed $3,000, if the value of the decedent's estate is less than $5,000, or if recovery against the decedent's estate would impose an "undue hardship" on the decedent's heirs. Only assets passing through the decedent's estate under N.C.G.S. Chapter 28A are subject to estate recovery.

Eligibility Appeals

A Medicaid applicant or recipient may appeal any decision by the county department of social services (DSS) affecting his or her eligibility for Medicaid or Medicaid coverage, including decisions that deny or terminate Medicaid benefits, determine the amount of a Medicaid deductible, determine the amount of a community spouse resource or income allowance, impose a transfer of asset sanction, deny an undue hardship claim, etc.

In order to appeal an adverse decision by the county DSS, the applicant or recipient must request a hearing, either orally or in writing, within **60 days** from the date of the decision (or within 90 days if good cause is shown for the delay). The appeal request should be made to the county DSS.

If a recipient's Medicaid benefits are terminated and she files an appeal within 10 days of that decision, she may continue to receive Medicaid benefits until the first appeal decision is made (but if she loses the appeal she may have to repay the state Medicaid program for any services she receives while the appeal is pending).

Local Hearing

Except in appeals in which the issue is whether the applicant or recipient is disabled, the first step in the appeal process is a local hearing held at the county DSS. The local hearing allows the county DSS to explain the decision and gives the applicant or recipient an opportunity to explain why she feels the decision is wrong. The local hearing should be scheduled within five calendar days after it is requested, but the person who is appealing may ask that it be postponed to a date not later than 15 days from the date the appeal was requested.

The person appealing has the right to be represented at the local hearing by an attorney or another person. The applicant or recipient, or his or her representative, has the right to see the applicant's or recipient's Medicaid record before the hearing.

The local hearing will be conducted, and the decision made, by an employee of the county DSS who was not involved in making the initial determination. The hearing is informal and the rules of evidence that apply in court proceedings do not apply. The worker involved in the decision will present a summary of the case. Copies of the documents relied on by the county will be attached to the summary. The applicant or recipient or his or her representative may ask the worker questions about the decision, may offer testimony, document, or other evidence, and must answer questions asked by the worker or the haring officer.

The local hearing officer will make a decision within five calendar days of the hearing and mail it to the person who appealed.

State-Level Hearing

In cases involving the applicant's or recipient's disability, the first step in the appeal process is a state-level hearing. In other cases, the state-level hearing is the second step in the appeal process and is requested if the applicant or recipient is not satisfied with the local hearing decision. When a local hearing has been held, a request for a state-level hearing must be requested, either orally or in writing, within 15 calendar days of the date of the local hearing decision.

The state-level hearing is conducted by a hearing officer from the state Division of Social Services. The hearing will be held at the county DSS. The state-level hearing usually will be held within three to six weeks after the appeal request is filed. The procedures for the state-level hearing are similar to those for the local hearing, but state-level hearings are tape recorded and witnesses are required to testify under oath.

The state level hearing is, for all practical purposes, an applicant's or recipient's last opportunity to introduce evidence in support of his or

her case. Consequently, it is very important to establish all necessary facts at this stage in the appeal process. If the case is appealed further, a transcript of this hearing together with the documents submitted will be the official record of the case.

The state hearing officer will issue a written decision and mail it to the applicant or recipient. If the applicant or recipient (or the county DSS) is not satisfied with the hearing officer's decision, she has ten days to ask that it be reviewed by the state's chief hearing officer. If a review is requested, the chief hearing officer will consider additional written or oral arguments but will not consider additional evidence that was not presented at the state-level hearing. If a review is not requested, the hearing officer's decision becomes the final agency decision. A final decision by the hearing officer or chief hearing officer should be issued within 90 days of the initial appeal request.

Judicial Review

A Medicaid applicant or recipient who is not satisfied with the final agency decision issued by the state hearing officer or chief hearing officer has the right to file a petition for judicial review in Superior Court. The petition must be filed within 30 days of receipt of the final agency decision. As a practical matter, filing a petition for judicial review requires the services of a lawyer.

Medicaid Service Appeals

Federal Medicaid regulations require the same notice and hearing rights for denials, reductions and cessations of Medicaid coverage for services as for Medicaid eligibility. If a Medicaid recipient is denied prior approval for Medicaid coverage for particular services, or if continuing coverage of an existing service is reduced or terminated, then the Division of Medical Assistance or its contractor must provide written notice to the recipient with appeal rights. These appeals generally involve whether a particular treatment is medically necessary, within Medicaid coverage rules, and is not experimental.

The informal hearing in service appeals is with a hearing officer of the Division of Medical Assistance. An informal appeal must be requested within 11 days of the date of the notice to the recipient. The formal hearing in these cases is before an administrative law judge in the Office of Administrative Hearings. A formal hearing must be requested within 60 days of the initial notice or, if an informal appeal was requested, within 60 days of the informal hearing decision. The same appeal process applies to CAP eligibility denials and terminations.

If continuing coverage for services by Medicaid is reduced or stopped, the recipient is entitled to continuation of the service at the prior level through both the informal and formal appeals.

Legal Authority

Federal Statute:	42 U.S.C. §1396 *et seq.*
Federal Regulations:	42 C.F.R. §430 *et seq.*
State Statute:	N.C. Gen. Stat. §108A-54 *et seq.*
State Administrative Rules:	10A N.C.A.C. Chapters 21 and 22

Sources of Additional Information

Division of Medical Assistance
N.C. Department of Health and Human Services
1985 Umstead Drive
Raleigh, NC 27603
(919) 855-4100
http://www.dhhs.state.nc.us/dma/

CARELINE 1-800-662-7030 (North Carolina Department of Health and Human Services Information and Referral Service)

DMA Adult Medicaid Eligibility and Policy Manual (available at county departments of social services and on-line at http://info.dhhs.state.nc.us/olm/manuals/dma/abd/man/index.htm.